TEACHERS' RETIREMENT BOARD

BENEFITS AND SERVICES COMMITTEE

SUBJECT: Impact of Medicare Prescription Drug Legislation ITEM NUMBER: 5

ATTACHMENT(S): 2

ACTION: ____ MEETING DATE: February 4, 2004

INFORMATION: X PRESENTER: Ed Derman

SUMMARY

In November 2003, Congress passed and the President signed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Medicare bill), the most far-reaching changes in Medicare since its creation in 1965. The focus on the bill and much of the publicity around it has been on the addition of outpatient prescription drug coverage. Specific details of the drug benefit as well as other provisions within the law will affect CalSTRS members and could affect future CalSTRS benefit programs. Because the effective date for most provisions are years in the future, many of the regulations and details are still to be determined. This item is designed to share what we know now about the impact of this legislation on CalSTRS programs and members. Staff will continue to update the Board as information becomes available.

BACKGROUND

The provision of health insurance is an issue of collective bargaining that is addressed at the local level. However, CalSTRS plays a role in California educators' health care. Specifically, in May 2003 the Teachers' Retirement Board evaluated different roles that CalSTRS could play with respect to health care benefits provided to CalSTRS members. The Board chose to expand CalSTRS' role as an educator about health care and to expand its role as financier of health insurance to the extent that funds are available. However, it will be very selective in the health care programs that it chooses to finance to ensure that consensus has been reached about members' acceptance of the programs. Because the health care environment is so volatile and the risks are so high, the Board decided that CalSTRS should not become a provider of health benefits at this time.

Presently, CalSTRS offers only one health benefit program. Under the Medicare Premium Payment Program (MPP) Program, CalSTRS pays the federal Medicare Part A (hospital) premiums for eligible Defined Benefit (DB) Program retired members who are not eligible to receive Medicare Part A coverage premium-free. These payments by CalSTRS began July 2001. CalSTRS also pays Medicare Parts A and B (medical) surcharges assessed by the Centers for

Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, for eligible DB members who enrolled in Medicare prior to July 1, 2001, and for whom CalSTRS is paying the Medicare Part A premium. As a convenience, CalSTRS also deducts Medicare Part B premiums from the members' allowance and forwards the payments to CMS. As of February 2004, CalSTRS pays the Medicare Part A premiums (approximately $2 million per month) for 5,857 retired DB Program members and CalSTRS deducts the Medicare Part B premiums (approximately $900,000 per month) for 11,611 retired DB Program members.

CalSTRS also deducts health insurance premiums from members' allowance checks and forwards them to insurance carriers.

PREVIOUS PROPOSALS FOR CALSTRS HEALTH BENEFITS PROGRAMS

Health Care Security Accounts

Federal law permits the establishment of Health Care Security Accounts that provide for contributions by employers to be made on a tax-deferred basis, earnings to be credited tax-free, and benefits to be paid on a tax-free basis, as long as the funds are used only to pay allowable medical expenses, as defined by the Internal Revenue Service. There was an in-depth presentation about Health Care Security Accounts to the Health Benefits Committee in March 2002. SB 147 (Torlakson), which would have required CalSTRS to establish Health Care Security Accounts, was introduced in 2003. However, the author did not pursue that proposal.

Catastrophic Prescription Drug Coverage

One of the proposals included in the May 2001 "A Review of Potential Health Care Benefits Programs Provided by the California State Teachers' Retirement System" (Health Care Report) was for CalSTRS to provide catastrophic prescription drug insurance. SB 461 (Torlakson) was introduced but not enacted in 2002 that would have required the Board to establish and administer a Catastrophic Prescription Drug Insurance (CPDI) Program.

CalSTRS Payment of Medicare Premiums

Paying the Medicare Part B premiums for all retired DB members was a second proposal in the Health Care Report. AB 2646 (Liu) was introduced but not enacted in 2002 that would have required that CalSTRS pay a portion of retired DB Program members' Medicare Part B premiums for a 10 year period.

Attachment 1 provides a more detailed explanation of these benefit proposals. Attachment 2 provides a glossary of the most commonly used terms concerning health benefits.

PROVISIONS OF THE MEDICARE BILL

Although somewhat focused on adding a prescription drug benefit to Medicare, the Medicare bill includes provisions covering many topics. Those most significant to CalSTRS members are discussed below.

Prescription Drug Benefits

The Medicare prescription benefits, to be called Medicare Part D, will be effective January 2006. Participation will be voluntary, but beneficiaries who do not enroll when they are first eligible may be charged increased premiums for late enrollment. The initial six month enrollment period begins November 15, 2005. Beneficiaries will be allowed to change their plan annually. Primarily, coverage will be offered by private insurance companies, called sponsors. In geographic areas in which there are less than two sponsors, beneficiaries will be able to secure drug coverage through the federal Medicare program. The projected premium for Medicare Part D could vary, but is expected to be an average of $35 per month or $420 per year. After beneficiaries pay the $250 annual deductible, Medicare will pay 75 percent of the prescription drug cost, while the beneficiary will pay 25 percent of the cost, until the total drug costs reaches $2,250 in a year. From $2,250 in total drug costs to $5,100, there is no Medicare reimbursement for costs. This is referred to as the "donut hole." Under the catastrophic coverage, when total drug costs exceed $5,100 in year, and an individual has incurred a total of $3,600 in out-of-pocket costs, Medicare coverage will resume. Medicare will pay 95 percent of the cost, with the beneficiary paying 5 percent (or a $2/$5 co-payment for drug). Beneficiaries with low incomes may pay less. All dollar figures will be adjusted annually based on drug cost increases. Because the actual drug benefit coverage that will be available will actually be delivered by commercial carriers and employer-funded plans, the details may vary.

The following table shows examples of how individuals with differing drug costs would be affected by Medicare Part D.

Drug costs	**Premium & Deductible**	**25% of drug costs after $250 to $2,250 +5% of drug costs over $5,100**	**Total paid by beneficiary**	**Total Paid by Medicare**
$500	$670	$62.50	$732.50	$187.50
$1,000	$670	$187.50	$857.50	$562.50
$2,000	$670	$437.50	$1,107.50	$1,312.50
$2,250	$670	$500	$1,170	$1,500
$3,000	$670	$1,250	$1,920	$1,500
$5,000	$670	$3,250	$3,920	$1,500
$10,000	$670	$3,595	$4,265	$6,155

With the significant gap in coverage, it would appear that offering catastrophic prescription drug coverage would help beneficiaries. However, there is a "True Out-of-Pocket" rule in the

Medicare bill. Only individuals or another person, such as a family member, can pay out-of-pocket amounts and have that payment count towards the cost thresholds that must be met for Medicare coverage to resume. Payments from a group health plan, insurer or other third party arrangement toward beneficiary cost sharing do not count toward those thresholds. Costs toward non-formulary drugs will also not count toward an individual's threshold. The federal government will take steps, such as auditing plans, to assure compliance.

Discount Drug Cards Interim Benefit
Because the regular prescription drug benefit does not become effective until 2006, the Medicare bill includes provisions for an interim benefit in the form of discount cards available beginning in Spring 2004. Some pharmaceutical companies already offer drug discount cards that provide discounts of up to 20 percent. The cards offered under this provision will also be offered by private companies, or sponsors, but will be endorsed by Medicare. Governmental agencies cannot be card sponsors. Beneficiaries are supposed to have a choice of at least two Medicare-endorsed drug discount cards, but will be allowed to enroll in only one drug card program at a time. The cards, which will cost up to a maximum of $30 per year, are projected to save beneficiaries 10 to 25 percent on prescriptions. Individuals will receive access to negotiated discounts from the card sponsor. Low-income seniors, without other prescription drug coverage, will not be required to pay the card fee and may also qualify for $600 toward drug purchases.

Incentives for Employers
To mitigate the concern that employers that presently provide prescription drug benefits to their retired employees will drop that coverage, the Medicare bill includes provisions to subsidize employers that offer such coverage. The subsidy will equal 28 percent of drug costs between $250 and $5000, and that the subsidy will be excludable from taxation. The $1,330 maximum subsidy per individual is based on actual incurred costs for the prescription drugs excluding administrative costs, discounts and rebates. These figures will be indexed to reflect future changes in costs. Government entities can receive the subsidy, but, because governmental entities are not subject to taxation, the exclusion from taxation will not be applicable. Employers are allowed maximum flexibility on plan design, formularies and networks, but the plan design must be actuarially equivalent to the Medicare standard benefits. In addition, employers can provide premium subsidies and cost sharing assistance to retirees who enroll in Medicare prescription plan and integrated plans and can negotiate preferential premiums. The employer plans must meet other requirements including submitting to an audit.

As employers, school districts that provide drug coverage to retirees and are seeking the subsidy would have to review their prescription benefits to determine if they are equivalent to or better than Medicare Part D. They must also isolate retiree-only costs and determine if they are actuarially equivalent to Medicare Part D.

Reforms to Increase Competition
The new Medicare bill includes numerous provisions designed to increase competition of private plans with the traditional fee for service Medicare plan. There are interim steps which begin in 2004 and 2006. A demonstration project, called the comparative cost adjustment program, is

scheduled to begin in 2010. This experiment will cover at least two million people in six metropolitan areas for six years. Each demonstration site must have two local private plans, with at least 25 percent of Medicare beneficiaries in private plans. Beneficiaries in these areas might have to pay Medicare Part B premiums that are as much as five percent more to remain in traditional fee for service Medicare if private insurance companies offer cheaper coverage. However, low-income beneficiaries are protected from increased premiums. Because premiums will be based on demographic and health risks of enrollees, some have raised concerns that private plans would allow only healthy and younger seniors to enroll, and that those in traditional Medicare would pay more.

There are other provisions in the bill that will affect reimbursement to physicians, hospitals and other providers and to increase rural health care reimbursements. Those provisions are not being discussed in this item.

Changes to Medicare Parts A and B

The Medicare bill also makes changes that affect the previously established Medicare benefits. Under Medicare Part A (hospital), provisions change reimbursement rates for providers, such as hospitals and ambulatory surgical centers.

The changes to Medicare Part B (medical) will affect beneficiaries more directly. For example, the Medicare Part B deductible, which has been $100 since 1991, will increase to $110 in 2005. Future deductible increases are indexed to Medicare Part B expenditures. In addition, no co-payment will be required for Home Health and the cost of voluntary physicals when a person first becomes eligible for Medicare; other screening procedures also will be covered, subject to deductibles and cost sharing. Finally, there will be demonstration projects to review the feasibility of additional benefits, such as chiropractic services.

One of the most significant changes is that Medicare Part B premiums will be based on income beginning in 2007 with a five year phase-in period. Presently, the premium that individuals pay for Medicare Part B represents only 25 percent of the total cost of the coverage, with the federal government paying the remaining 75 percent. Under the new provisions, the premiums charged to individual beneficiaries will be as follows:

Annual adjusted gross income	Premium as percent of total cost
Under $80,000	25 percent
$80,000 to $100,000	35 percent
$100,000 to $150,000	50 percent
$150,000 to $200,000	65 percent
Over $200,000	80 percent

The income limits are doubled for married couples. Beneficiaries will be notified of their premiums at the beginning of each year and may appeal the charged premiums if their family situation has changed. In order to establish the appropriate Medicare Part B premiums, the

Internal Revenue Service may disclose tax return information to the Social Security Administration.

Other Reforms

There are some additional regulatory and contract reforms. For example, the time required for introduction of generic drugs has been shortened. In addition, reimportation of drugs from Canada will be approved, but only with safety certification from the Food and Drug Administration. However, CMS is barred from negotiating lower drug prices for seniors and there are no price controls on prescription medication costs.

A new Medicare Beneficiary Ombudsman has been created. This position is to provide assistance to Medicare beneficiaries with respect to complaints, grievances and requests for information. Further, Medicare appeal adjudication is to be transferred by October 2005 from the Social Security Administration to the Department of Health and Human Services.

Starting in 2005, Medicare Trustees will be required to make an annual determination whether Medicare funding through general federal revenues exceeds 45 percent. If this occurs for two years, the trustees must issue a "funding warning," which will trigger requirements that the President submit legislation to correct the funding.

Health Security Accounts

Another major feature of this bill is to allow eligible individuals to establish Health Security Accounts (HSA). Although this provision became effective January 2004, some of the guidelines are not yet available. Unlike the demonstration Archer Medical Savings Accounts, HSA are not limited to individuals who work for small employers (those with 50 or fewer employees) and the HSA are completely portable. Active workers with high deductible plans can contribute up to the amount of the policy's annual deductible, subject to a maximum of $2,600 for individuals or $5,150 for families into tax-free accounts. Both the employer and employee contributions are included in the above limits. A high deductible plan has a deductible of at least $1,000 per individual or $2,000 per family. Required out-of-pocket expenses cannot exceed $5,000 per individual or $10,000 per family. Contributions can be made tax-free, earned interest is tax-free even if the individuals do not itemize deductions, and distributions for medical costs as defined in Section 213(d) of the IRS code are tax-free. Unlike flexible spending accounts, any unused account balances can be carried over into subsequent years.

Allowable deductions are more restrictive for working individuals than those who are retired. Money not spent in any year can be rolled-over for use in the future. Withdrawals for non-medical costs will be taxable and may be subject to a 10 percent penalty. There is a catch-up feature, under which individuals age 55 to 64 may contribute an additional $500 the first year. This amount will increase $100 each year until reaching a maximum of $1,000 in 2009. Employer contributions are not subject to Social Security taxes, but if an employer contributes to a HSA, it must make comparable contributions on behalf of all employees. Individuals eligible for Medicare may not make contributions to HSA, although prior contributions in the HSA can

continue to be used by Medicare recipients. The allowable contribution levels are indexed, and will therefore increase over time.

Similar to Individual Retirement Arrangements (IRA) funds, HSA contributions are held by qualified HSA trustee or custodian, often insurance companies, banks, or other financial institutions. These trustees or custodians must be approved by the Internal Revenue Service (IRS).

Some feel that the introduction of Health Security Accounts combined with the pressure of rising cost of health insurance will encourage more employers to offer high deductible plans in the future.

POSSIBLE IMPACT ON FUTURE CALSTRS HEALTH BENEFITS

The enactment of this bill could affect how future CalSTRS health benefit programs are designed, if the Board determines that such programs would be valuable to members, and the resources to fund those programs become available.

Health Care Security Accounts

When Health Care Security accounts were first introduced as a possible means for CalSTRS members to finance their retiree health care costs while working, there were two drawbacks identified by CalSTRS members. First, contributions into the accounts could only be made by employers; unlike 403(b) plans and IRAs, individual employees had no discretion on how much was contributed into their individual accounts. The only control that employees had over this was through the collective bargaining process, in which the employer and the bargaining unit could collectively determine how much was contributed on behalf of all affected employees.

The second concern raised by members over the Health Care Security accounts was that providing a means for employees to accumulate resources for health care, to be used at retirement, could provide an opportunity for employers to reduce their level of financial commitment to retiree health care, particularly if the funds being contributed into the account are being contributed by employers. As a result, members were concerned that there would be little net benefit to members from the accounts, and potentially a shift in financial responsibility for retiree health care from the employer to the individual member.

Although Health Security Accounts (HSA) under the Medicare bill address one of these concerns, it probably exacerbates the other concern. Individual workers can elect to make personal contributions to their HSA, thereby permitting the employee to decide how much to put into the account. Employers also could make contributions to these accounts. On the other hand, the only members who can participate in an HSA are those who participate in a high deductible health insurance program. As a result, not only would the employer potentially scale back the level of retiree health care coverage in response to the availability of these accounts, the employer would be required to reduce the level of coverage for active employees by requiring

them to participate in a high deductible plan. In other words, not only might retirees face increased out-of-pocket costs for health care, so would active employees, although in both cases, the increased costs could be funded from these tax-favored accounts.

In order to be able to manage a HSA program as defined by the Medicare bill, CalSTRS would have to be a qualified IRA trustee or custodian. Because CalSTRS does not currently meet the qualifications for such a role, it could not administer the new HSA program, even if the Board wanted CalSTRS to assume that role. However, CalSTRS could still establish and administer a HCS account program as described in Attachment 1.

Catastrophic prescription drug coverage
Medicare Part D provisions include a gap in coverage between $2,250 and $5,100 of drug costs during which beneficiaries receive no reimbursement for their drug costs. On the surface it would appear that by offering catastrophic prescription drug coverage, CalSTRS would help retired members. CalSTRS would pay some or all of $2,850 in costs in that gap of coverage, and which point, Medicare coverage resumes. However, with the "True Out-of-Pocket" rule in the Medicare bill, any benefits that CalSTRS provided that would cover the gap in coverage would eliminate or significantly delay member eligibility for the catastrophic Medicare coverage. To the extent that CalSTRS benefits delayed the resumption of Medicare coverage for prescription drug costs, there would a shift in financial responsibility from Medicare to CalSTRS.

CalSTRS Payment of Medicare Premiums
CalSTRS currently pays the Medicare Part A premiums for those members who are not otherwise eligible for premium-free Medicare Part A coverage. Because anyone participating in Medicare Parts B or D also would be subject to a premium, CalSTRS could extend the current program to pay all or a portion of Medicare Parts B and/or D.

Extending the benefit in this manner would not be inexpensive. The Medicare Part B premium in 2004 is $66.60 per member. If CalSTRS paid the entire Medicare Part B premium for the 135,000 retired members age 65 or older, the annual cost would be $108 million. Under the Medicare bill, individuals with incomes higher than $80,000 will pay higher Medicare Part B premiums. If CalSTRS opted to pay members' Medicare Part B premium, the amount paid by CalSTRS would probably have to be limited in the case of those members whose income exceeded $80,000 per year. It may be better to have CalSTRS subsidize a specific dollar amount toward members' Medicare Part B rather than the whole premium (As of June 30, 2003, approximately 1,500 members receive CalSTRS allowances of $80,000 or more per year.) There are two reasons for this. First, CalSTRS does not have visibility of members' entire income. As a result, CalSTRS cannot project the liability it is assuming for members whose other income would subject the member to higher Medicare Part B premiums. Second, if CalSTRS paid the entire premium, or the same percentage of the premium for all members, it would create a situation in which CalSTRS would be paying a higher benefit on behalf of members who have higher incomes.

CalSTRS could also pay members' Medicare Part D premiums. At a projected cost of $35 per month the cost for all 135,000 retired members age 65 or more would be $56.7 million in 2006. It appears that CalSTRS payment of all or a portion of members' Medicare Part D premiums will not count toward the "True out-of-pocket" rule. Because Medicare Part D is a voluntary benefit, paying these premiums would not necessarily be a benefit for all retired members age 65 or more. Many members already have a prescription drug benefit, and their current coverage may be more extensive than what will be provided by Medicare. Assuming the current coverage continues to be available to those members, they would have no reason to participate in the Medicare program, and would not benefit from the CalSTRS program. When CalSTRS began paying the Medicare Part A premium for members who did not qualify for premium-free coverage, a number of members who did receive premium-free coverage were critical of the program because they did not receive any benefit from it. One means to mitigate that concern in this case would be for CalSTRS to pay a similar amount to offset a member's cost of the alternative drug program. Similar to the proposal to pay Medicare Part B premiums, a CalSTRS program will need to limit the amount paid because Medicare Part D premiums could vary depending by area.

Finally, CalSTRS could deduct members' Medicare Part D premiums as a service. CalSTRS already has a working relationship with and is CMS' largest group payer. However, Medicare Part D premiums will be paid to sponsors rather than CMS. Therefore, this service is more similar to a deduction of health insurance premiums than deduction of Medicare Part B premiums.

CONCLUSION

The enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 could have a significant effect on the provision of the health care for CalSTRS members, both while they are working and after retirement. If CalSTRS had additional resources available, a benefit program to complement that act could be established that is consistent with the Board's direction concerning the role of CalSTRS in health care. However, the provisions of the federal bill would likely require somewhat more complicated provisions of the CalSTRS program in order to avoid equity problems among CalSTRS members.

CALSTRS HEALTH BENEFIT ALTERNATIVES

INTRODUCTION

The health benefits discussed below have been suggested as benefits that CalSTRS should offer to its members.

HEALTH CARE SECURITY ACCOUNTS

Federal law provides a mechanism for a government entity, such as California State Teachers' Retirement System (CalSTRS), to administer Health Care Security (HCS) accounts. CalSTRS would operate a trust, separate from the pension trust such as the Teacher's Health Benefit Fund, to administer the accounts. School districts currently have the legal authority to administer this program, whereas CalSTRS would have to seek legislative approval to administer a HCS account program.

Funding the Accounts

Under the HCS Program, nominal accounts would be established for each program participant. Contributions, typically made while a member is actively working, can be made to HCS accounts that would be excluded from the taxable income and tax-free earnings would be credited to the member's account. Funds in the member's account could pay directly or be used to reimburse allowable medical expenses, as defined by the Internal Revenue Service, without having to include these payments in the member's taxable income. To simplify program administration, CalSTRS would invest the funds, although in some similar programs elsewhere in the United States, participants can direct the investment of account balances in a limited manner, with the account balances being based on the success of those investments. Account balances would be available to pay allowable medical expenses only after the member has retired.

One significant requirement of a HCS Program is that individuals would have no discretion on how much is contributed to their accounts. The level of contribution, which can be a flat dollar amount or a percentage of compensation, would be determined either on a statewide level or at the employer level. If the program is at the employer level, the contributions would be determined through collective bargaining. Funds could also be established for retired members. However, these accounts would not have the same opportunity to grow with interest.

Although the funds in the employees' accounts would be considered to be employer funds, there are a number of ways that the accounts could be funded. First, employer contributions could be increased, with the increased contributions credited to the HCS accounts. Second, the percentage paid by the State General Fund to CalSTRS could be increased, with the increased contributions credited to these accounts. A third option is to reduce employer contributions to the Defined Benefit (DB) Program, offset by available

resources in the DB Program, and redirect the balance of the employer contributions to the HCS accounts. Finally, contributions paid by members to the State Teachers' Retirement Plan (STRP), which includes the DB Program, the Defined Benefit Supplement Program and the Cash Balance Benefit Program, could be increased, with the actuarial equivalent of the employers' contributions otherwise payable to the STRP reduced and redirected to HCS accounts.

Funds would accumulate in member's HCS account during the member's career and be credited with interest. Once the member retired from CalSTRS, the funds would be available to pay, tax-free, medical expenses that are allowable under the Internal Revenue Code. These could be expenses of the member or their dependents, including Medicare Part B premiums or premiums for long-term care insurance. Upon the member's death, the funds could continue to be used to pay the allowable medical expenses of the member's surviving dependents. If there are no surviving dependents, the funds could be distributed to the member's estate or the member's beneficiaries, but such distributions would be taxable.

Because the funds in the HCS account would be considered employer funds, the availability of the funds if the member terminated membership in the STRP prior to retirement would be treated differently than occurs in the STRP. A member can receive a refund of STRP member contributions and credited interest if the member terminates service in the STRP, but the funds in the member's HCS account would remain in that account even if the member terminated service and withdrew his or her contributions from the STRP. The HCS Program could, however, permit such a terminated member to pay for or reimburse medical benefits costs from his or her HCS account, either immediately or once the member reached normal retirement age, which currently is defined in the Teachers' Retirement Law as age 60. Alternatively, there could be vesting requirements imposed for the HCS Program, and any balances in the accounts of participants who did not vest under the program would represent an actuarial gain that would be distributed among the vested participants in the HCS Program.

Administering the Accounts

The administration of this program would have two components: (1) collecting and tracking contributions paid, plus account earnings, on behalf of each participating member and (2) paying allowable medical expenses after the member's retirement. Either component could be handled in one of two ways: CalSTRS could administer the function internally, or it could contract with a third party to administer the component.

The cost-effectiveness of administering the collection and tracking of contributions and earnings during the members' employment depends on whether the program would be implemented statewide or on a district-by-district basis, and, if the latter, how many members would be covered by the program. In addition, developing the internal capability to maintain contribution and interest records would require modifications to the corporate database. Whether to pay claims internally or through a third party administrator also depends on how the program is implemented. Limiting allowable medical expenses, such as for the payment of health benefit premiums, would make it

possible for CalSTRS staff to administer the program, although additional staff would be required. Such a restriction would, however, severely limit the value of the program and prevent members from using the funds to pay deductibles, co-payments and other out-of-pocket expenses. There are outside entities that process claims that could be hired to assume these responsibilities.

CATASTROPHIC PRESCRIPTION DRUG INSURANCE PROGRAM

SB 461 (Torlakson) in 2002 proposed that retired DB Program members with 25 years of credited service be covered in a Catastrophic Prescription Drug Insurance (CPDI) Program. In addition, there was an option to include retired members with 10 or more years of service, with the Board establishing a graduated scale of premium support based on years of service. The CPDI Program was to be fully automated, coordinated with retired DB Program members' medical insurance program, and secondary to any Medicare benefits. The Board would have been authorized to specify and modify deductibles, co-payments, and maximum level of benefits, but the cost of the program was limited to $650 million over a 10-year period based on 2002 dollars.

If the CPDI Program were to be administered in-house, CalSTRS would have to develop and establish significant staff and system capacity and expertise. Alternatively, CalSTRS could contract with a third party pharmacy benefits manager to administer the program. Because of the requirement to be secondary to Medicare and coordinate with other insurance programs, CalSTRS would need to secure the cooperation of all school districts and their insurance providers including CalPERS and Medicare.

Fiscal Impact

The cost estimates included in the May 2001 Health Care Report are no longer applicable as the cost of prescription drugs, particularly for seniors, has risen so rapidly. In addition, the number of members and their other prescription coverage could affect the cost of a CPDI program significantly. Because retired DB members' health insurance benefits, with which the CPDI Program would coordinate, vary greatly, some retired DB members would receive no benefit while others would receive a significant benefit from the CPDI Program.

PAY MEDICARE PART B PREMIUMS

Most people are eligible for Medicare Part A (hospital) without paying a premium. For those eligible retired Defined Benefit Program members who do not receive it premium-free, CalSTRS can pay the Medicare Part A premiums under the Medicare Premium Payment Program. However, most people pay their own Medicare Part B (medical) premium. In 2004, the total Medicare Part B premium is $266.40, but the federal government underwrites 75 percent of the premium. Therefore, individuals pay $66.60 per month for Medicare Part B.

The one-year cost for 2004 to pay the members' portion of Medicare Part B premiums for the approximately 135,000 retired DB members age 65 or more would be $108 million.

Administration

Although it appears simple to pay Medicare Part B premiums for our members, it is not because CalSTRS members fall into at least nine categories as it relates to their Medicare Part B premiums. While CalSTRS deducts the Medicare Part B premium from over 11,000 CalSTRS members' allowance checks, there are some retired CalSTRS members who receive a Social Security or other federal benefit check from which their Medicare Part B premium in deducted each month. In addition, there are members who receive reimbursement from their districts or another source for their Medicare Part B premiums.

CalSTRS would have to significantly increase staff and system capabilities to handle the change in workload from establishing 11,000 members' deductions to administering 135,000 members' deductions or reimbursements.

INTRODUCTION

This glossary provides definitions of words and concepts that are helpful in understanding the Medicare bill analysis.

Adverse selection
Situation in which an insurance carrier enrolls members who have a disproportionally higher risk than the average members of a group as a whole.

Archer Medical Savings Accounts
Created as a pilot project for self-employed individuals and employees of employers with 50 or fewer employees with high deductible health plans. In 2001, the minimum deductible was $1,600 for one person and $3,200 for a family. The maximum out of pocket expenses for an individual was $3,200 and $5,850 per family.

Beneficiary
Term that is used to describe an individual covered by Medicare.

Centers for Medicare and Medicaid Services (CMS)
CMS is a federal agency within the U.S. Department of Health and Human Services. Formerly called the Health Care Financing Administration (HCFA), it administers Medicare, Medicaid, the Health Insurance Portability and Accountability Act, and other programs.

Cherry Picking
The reverse of adverse selection describing the situation in which an insurance provider only accepts younger and healthier beneficiaries for enrollment. This term has been used because some have voiced the concern that under the revised Medicare program, insurance companies will 'cherry pick' beneficiaries leaving tradition Medicare with only the older and sickest beneficiaries, thereby bankrupting the traditional Medicare program.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 is the federal law that obligates employers to offer continued health insurance coverage to terminated employees and their dependants for designated periods of time. The former employee or dependent typically pays the premium plus an administrative cost. This is separate and apart from provisions of California AB 528 under which districts are obligated to offer newly retired members the option to pay for their own health insurance.

Coinsurance
The percentage of the Medicare-approved amount that the beneficiary has to pay after the deductible has been satisfied.

Coordination of Benefits
The process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Eliminates duplicate payment when a person is insured under two contracts.

Co-payments
A cost-sharing arrangement of a health plan in which the beneficiary pays a fixed fee for a specific service (such as $10 for an office visit) in addition to deductibles and coinsurance, often on a per service basis. Co-payments are used to discourage inappropriate use of benefits and to help finance health benefit plans.

Cost sharing
The term used to describe the split in payments between the insurance and the beneficiary, generally after the beneficiary has paid a deductible. Medicare Part B has a cost sharing arrangement of 80 percent paid by Medicare and 20 percent paid by the beneficiary.

Deductible
An amount that the beneficiary must pay prior to receiving any reimbursement from insurance. Some deductibles are per services, such as the Medicare Part A deductible of $890 for 60 days in a hospital. Other deductibles are computed annually, such as the Medicare Part B deductible which is presently $100 per year.

Disease management
An information-based process involving the continuous improvement of value in all aspects of care (prevention, treatment and management) throughout the continuum of health care delivery. Ultimately it attempts to control costs by using the most effective treatments as early as possible.

Experience Rating
A health insurance plan that bases premiums on the past cost experience of the enrolled group.

Fee for Service plan
A private insurance plan under which the beneficiary can go to any doctor or hospital that accepts the plan's payments. The providers are paid for each service they provide as opposed to receiving a fixed amount for all of the beneficiaries' health care needs.

Formulary (or drug formulary)
A preferred drug list selected by a panel of physicians and pharmacists that fosters substitution of generic or therapeutic equivalents on a cost-effective basis. In some plans, doctors must order or use only drugs listed on the health plan's formulary. Often the co-payment structure steers beneficiaries to formulary drugs by requiring a higher co-payment for prescriptions not on the plan's formulary.

Generic drug
A prescription drug that is chemically equivalent to a brand-name product with an expired patent, dispensed under its generic chemical name. Generally generic drugs are less expensive than branded products.

Health and Human Services
Headed by Secretary Tommy Thompson, this is U.S. government's principal agency for protecting the health of all Americans and providing essential human services. It includes the National Institutes of Health, the Food and Drug Administration, and Center for Disease Control and Prevention as well as the Centers for Medicare and Medicaid Services and the Administration on Aging.

Health Care Report
"A Review of Potential Health Care Benefits Programs Provided by the California State Teachers' Retirement System," published in May 2001 pursuant to Chapter 874, Statutes of 2000 (AB 2383—Keeley) that directed CalSTRS to evaluate and provide options for prescription drug coverage and health insurance programs for retired members and to report to the Legislature on solutions and funding of those solutions.

Health Maintenance Organization (HMO)
A health plan, paid for through a prepaid premium, which offers individuals a range of health benefits, including preventative care, for a monthly fee and a range of co-payments. Members of an HMO must use the designated physicians and providers, other than with the referral of members' primary care physician or in an emergency.

Individual Retirement Arrangement (IRA)
Includes both Individual Retirement Accounts and Individual Retirement Annuities. Allows individuals to contribute funds into trust or custodial accounts. There are tax advantages, but the maximum contributions are limited each year. Distribution must started no later than the year following the year in which the individual turns age 70½.

Internal Revenue Service (IRS)
The nation's tax collection agency administers the Internal Revenue Code.

Mail Order Drug Plans
An efficient mechanism for dispensing maintenance drugs for chronic illnesses. Typically, the co-payment required for a 90-day supply is the same as or only slightly more than the cost of a 30-day supply through retail pharmacists.

Medicare
Medicare is the federal health insurance program for citizens and permanent residents age 65 or more. In addition, individuals who are judged to be disabled and received social security disability for 24 or more months may also receive Medicare as will people with other specific disabilities such as End-Stage Renal disease.

Medicare is split into parts:

- Medicare Part A pays for inpatient hospital, limited skilled nursing care, hospice care, and some home health care. Most people earn Medicare Part A premium-free by paying the Medicare tax and earning 40 or more Medicare credit.
- Medicare Part B covers doctors' services, outpatient hospital care, durable medical equipment and some medical services not covered by Medicare Part A. Most beneficiaries pay their own Medicare Part B premiums. After paying a deductible, the beneficiary will generally pay 20 percent and Medicare will pay 80 percent of charges for care.
- Medicare Part C is the Medicare + Choice portion of Medicare under which private organizations offer supplemental coverage or Medi-gap policies to beneficiaries for an additional premium. Under the new bill, Medicare Part C will be called Medicare Advantage.
- Medicare Part D is the newly legislated prescription drug coverage.

The traditional Medicare plan is a pay per visit health plan that allows beneficiaries to go to any doctor, hospital or other health care provider who accepts Medicare. Beneficiaries must pay the deductible and their share of costs or co-insurance.

Medicare Premium Payment Program
Established in 2000 with first payments in July 2001, CalSTRS pays the Medicare Part A premiums for eligible retired Defined Benefit Program members who do not get Medicare Part A premium-free from another source. CalSTRS also pays Medicare Parts A and B surcharges assessed by CMS for eligible DB members who enrolled in Medicare prior to July 1, 2001, and for whom CalSTRS is paying the Medicare Part A premium.

Medicare Trustees
Established by the Social Security Act to oversee the financial operations of Medicare, the Medicare Board of Trustees is composed of six members. Four members serve by virtue of their positions in the federal government: the Secretaries of the Treasury, Labor and Health and Human Services, and the Commissioner of Social Security. The other two members are appointed by the President and confirmed by the Senate as public representatives. The two current public Trustees, John L. Palmer and Thomas R. Saving, began serving their four-year terms on October 28, 2000. The Administrator of CMS is designated as Secretary of the Board.

Medi-gap Policy
A Medicare supplemental policy, sold by private insurance companies, designed to pay for services not covered by Medicare. In most states, there are standard plans, labeled A through J. With the implementation of Medicare Part D, the design of these some of these plans will change and no longer offer prescription drug benefits.

Open Enrollment Periods
Periods during which a person may join or change health insurance plans.

Out-Of Pocket
The funds, including deductibles, co-payments, or coinsurance, that a beneficiary must pay for his or her health care.

Over the counter medication
Medications that one can purchase without a prescription from a physician. Generally, the cost of over the counter medication is not covered by health plans or Medicare.

Premium
The amount of money a beneficiary pays for insurance coverage.

Pharmaceutical Benefits Manager
Service vendors that contract to manage prescription drug benefits. Services typically include development of formularies and drug utilization review.

Preferred Provider Organization (PPO)
A managed care plan in which beneficiaries use doctors, hospitals, and providers that belong to the network. Beneficiaries can use providers outside the network for an additional cost. Members of a PPO can generally choose their own physician and do not need a referral from their primary care physician to see a specialist.

Prescription medication
Controlled medication that must be prescribed by a physician.

Section 213(d) of the IRS code
The portion of the IRS code that defines medical care, including costs for diagnosis, mitigation, treatment or prevention of disease, transportation primarily for and essential to medical care, and insurance costs including Medicare Part B premiums. Costs for prescription drugs are included.

Social Security Administration (SSA)
The federal agency that is responsible for enrolling beneficiaries in Medicare.

Sponsors
Private organizations such as insurance companies or pharmaceutical benefits managers that offer prescription discount cards or later prescription benefits plans in a designated geographic area(s) as designed by CMS. Governmental organizations cannot be sponsors. Also, the companies that will offer alterative health insurance under the demonstration project which is to begin in 2010.